State of Montana
Fetal, Infant and Child Mortality Review
Case Report

This case report should be completed on all fetal, infant and child deaths reviewed by your local Fetal, Infant and Child Mortality Review team.

The purpose of this report is to help develop a better understanding at the local and state level of how and why the child died and what can be done to deter future preventable deaths.

The information in this report will be tabulated by the Department of Public Health and Human Services FICMR Program and made available to the counties and state as aggregate data.

This reporting tool is a confidential document, protected by Montana Law 50-19-404, and is not subject to disclosure under the public records law.

Case Number: _____-_____
County Number Sequence of Review/Year of Death/Fetal (F), Infant (I) or Child (C)

County Performing the Review: #_____
(If Different Than Above)

Instructions for Determining Review County For Out of County Deaths:

1) Fetal Death: The death is reviewed by county of residence of the mother. The FICMR Coordinator in the county where the death occurred will assist in obtaining the necessary information for the reviewing county.
2) Child Death: The factors in each case will determine which county completes the review. Child deaths should probably be reviewed by the county in which the death occurred. This allows for development of community action/preventability plans.

Instructions for Determining the Case Report Number When Performing Review for Another County:

1) When reviewing a death for another county (through MOU/Agreement), use their county number in the "case number." Put your county number in the space allowed for "county performing the reveiw".
2) When reviewing a child death that occurred in your county (but child resided in another county), and it is decided that your county will determine preventability and recommendations, utilize your county number in the "case number."

Send Completed Case Report To:
Montana FICMR Program
CACH Section, 1400 Broadway
Cogswell Building Room C314
Helena, MT 59620

A. IDENTIFICATION OF THE FETUS/INFANT/CHILD

1. DATE OF BIRTH
mm / dd / yyyy

2. DATE OF DEATH
mm / dd / yyyy

3. CAUSE OF DEATH FROM DEATH CERTIFICATE:

4. AGE
a. infant (<1 year) _____ days/months
b. child (>1 year) _____ years
c. fetal _____ weeks gestation

5. RACE (Check one or more)
a. ☐ White
b. ☐ Black
c. ☐ Asian or Pacific Islander
d. ☐ American Indian/Alaskan Native
e. ☐ Other

6. HISPANIC
a. ☐ Yes
b. ☐ No
c. ☐ Unknown

7. SEX
a. ☐ Male
b. ☐ Female

8. RESIDENCE:

9. COUNTY WHERE DEATH OCCURRED:

10. PLACE WHERE THE INJURY OR FATAL INCIDENT OCCURRED
a. ☐ Childís Home
b. ☐ Other Home
c. ☐ Hospital
d. ☐ Rural Road
e. ☐ Highway
f. ☐ Street
g. ☐ Farm
h. ☐ Private Property
i. ☐ Unlicensed Day Care
j. ☐ Licensed Day Care
k. ☐ Detention Facility
l. ☐ Body of Water
m. ☐ Work Place
n. ☐ Foster Home
o. ☐ Other

11. SUPERVISION (Check all that apply) ☐ **N/A** (I.E. Fetal Death)
Person(s) in charge of watching the decedent at the time of injury/event
a. ☐ Natural Father
b. ☐ Natural Mother
c. ☐ Adoptive Father
d. ☐ Adoptive Mother
e. ☐ Stepfather
f. ☐ Stepmother
g. ☐ Foster Father
h. ☐ Foster Mother
i. ☐ Other
j. ☐ Parentís Male Partner
k. ☐ Parentís Female Partner
l. ☐ Sibling Less Than 18 Years of Age
m. ☐ Due to Age, Supervision Not Needed

12. SUPERVISION ADEQUACY
☐ **N/A** (Fetal Death or Supervision Not Needed)
Did the team believe the decedent was adequately supervised
a. ☐ Yes
b. ☐ No
c. ☐ Unsure

13. IF SUPERVISION ADEQUACY IS NO OR UNSURE
A. Did the person(s) in charge appear to be impaired in any manner that would prevent them from adequately supervising
a. ☐ Yes
b. ☐ No
c. ☐ Unknown
B. Was the person(s) in charge preoccupied, distracted or asleep at the time of the injury/event
a. ☐ Yes
b. ☐ No
c. ☐ Unknown
C. Were there extenuating circumstances that prevented adequate supervision
a. ☐ Yes
b. ☐ No
If yes explain:

14. HEALTH INSURANCE
a. ☐ Private Insurance
b. ☐ Medicaid
c. ☐ Uninsured
d. ☐ IHS
e. ☐ CHIP
f. ☐ Other
g. ☐ Unknown

15. MEDICATIONS INFANT/CHILD ON AT TIME OF DEATH:
☐ None ☐ Unknown

B. PARENT/CARE GIVER/HOUSEHOLD INFORMATION

1. MARITAL STATUS OF MOTHER OR MAIN CARE GIVER AT TIME OF FETAL/INFANT/CHILD DEATH
a. ☐ Married
b. ☐ Single
c. ☐ Unknown

2. AGE OF MOTHER: ☐ Unknown

3. RACE OF MOTHER
a. ☐ White
b. ☐ Black
c. ☐ Asian or Pacific Islander
d. ☐ American Indian/Alaskan Native
e. ☐ Other

4. HOMELESS OR MULTIPLE RESIDENCES
a. ☐ Yes
b. ☐ No
c. ☐ Unknown

5. EVIDENCE OF PREVIOUS ABUSE/NEGLECT OF CHILD/SIBLING
a. ☐ Yes
b. ☐ No
c. ☐ Unknown
If Yes ...
d. ☐ Unsubstantiated
e. ☐ Substantiated
f. ☐ Alleged
g. ☐ Pending
h. ☐ Unfounded

6. OTHER CHILDREN IN THE FAMILY UNIT
a. ☐ Yes
b. ☐ No
c. ☐ Unknown
If Yes ...
a. ☐ 1
b. ☐ 2-3
c. ☐ 4+

C. INVESTIGATION

1. CORONER CASE
a. ☐ Yes
b. ☐ No
c. ☐ Should Have Been

2. AUTOPSY PERFORMED
a. ☐ Yes
b. ☐ No
c. ☐ Should Have Been
d. ☐ Uknown

a. CAUSE OF DEATH LISTED ON AUTOPSY:

3. WAS A TOXICOLOGY DONE
a. ☐ Yes
b. ☐ No
c. ☐ Unknown
If Yes...
1. ☐ Infant
2. ☐ Child
3. ☐ Mother
4. ☐ Father
5. ☐ Care Giver
6. ☐ Other

Findings:

4. INVESTIGATION CONDUCTED AT SCENE OF INCIDENT

a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ NA

1. If Yes...(Check all those that apply)

a. ☐ By Coroner c. ☐ By Fire Investigator

b. ☐ By Law Enforcement d. ☐ By EMS e. ☐ By Other

5. OTHER INVESTIGATION BY LAW ENFORCEMENT ☐ N/A

a. ☐ Not Conducted d. ☐ Pending

b. ☐ Conducted, No Arrest

c. ☐ Conducted, Arrested For: _____

6. INVESTIGATION BY CHILD & FAMILY SERVICES ☐ N/A

a. ☐ Not Conducted

b. ☐ Conducted, Abuse/Neglect Not Substantiated
Date Completed _____

c. ☐ Conducted, Abuse/Neglect Substantiated
Date Completed _____

d. ☐ Pending Investigation, No Children Removed

e. ☐ Other Children Being Removed From Home ☐ Yes ☐ No

7. PRIOR CHILD & FAMILY SERVICES INVOLVEMENT

a. ☐ Yes b. ☐ No c. ☐ Unknown

a. If Yes...

1. ☐ With Child 4. ☐ Total # of Referrals to CFS

2. ☐ With Anyone Else in Family

3. ☐ With the Caretaker (other than family members)

8. ACTION BY PROSECUTOR ☐ N/A

a. ☐ No Action d. ☐ Charges Filed For:

b. ☐ Pending or In Progress

c. ☐ Suspected Perpetrator, No Charges Filed

9. FACTORS THAT COULD HAVE CONTRIBUTED TO THE DEATH

a. ☐ Domestic Violence f. ☐ Lack of Supervision

b. ☐ Neglect (physical/mental/emotional) g. ☐ Environmental

c. ☐ Child Abuse h. ☐ Abandonment

d. ☐ Alcohol i. ☐ Other:

e. ☐ Drugs j. ☐ N/A

D. SERVICES PROVIDED

1. LIST SERVICES PROVIDED AS A RESULT OF THE DEATH

(Check all that apply)

a. ☐ Bereavement Counseling c. ☐ Funeral Arrangements e. ☐ Mental Health Services g. ☐ Other:

b. ☐ Economic Support d. ☐ Emergency Shelter f. ☐ Child Foster Care h. ☐ None Known

E. MANNER, AND CIRCUMSTANCES OF DEATH *(Including Fetal)*

1. OFFICIAL MANNER OF DEATH FROM DEATH CERTIFICATE

a. ☐ Natural d. ☐ Homicide

b. ☐ Accident e. ☐ Undetermined

c. ☐ Suicide

2. NATURAL DEATH TO CHILD AGE >1 YEAR ☐ N/A

Underlying Cause:

a. ☐ Respiratory/Asthma e. ☐ Cardiac

b. ☐ Cancer/Neoplasm f. ☐ Infectious Disease

c. ☐ Cerebral g. ☐ Other:

d. ☐ Congenital Anomalies

3. NATURAL DEATH TO INFANT AGE 0-1 YEAR INCLUDING SIDS ☐ N/A

(Obtain birth record for completion)

a. Age at Death

1. ☐ Fetal 4. ☐ 48 Hours-5 Weeks

2. ☐ 0-23 Hours after Birth 5. ☐ 6 Weeks-5 Months

3. ☐ 24-47 Hours 6. ☐ 6 Months-1 Year

b. Gestational Age

1. ☐ <24 Weeks 3. ☐ 32-37 Weeks

2. ☐ 24-31 Weeks 4. ☐ >37 Weeks

c. Birth Weight in Grams

1. ☐ <750 3. ☐ 1,500-2,499

2. ☐ 750-1,499 4. ☐ >2,500

d. Multiple Birth ☐ Yes ☐ No

e. Total Number of Prenatal Visits

1. ☐ None 3. ☐ 4-6 5. ☐ >9

2. ☐ 1-3 4. ☐ 7-9

f. First Prenatal Visit Occurred During

1. ☐ First Trimester

2. ☐ Second Trimester

3. ☐ Third Trimester

4. ☐ Unknown

g. Medical Complications/Infections During Pregnancy

☐ Yes ☐ No ☐ Unknown (check all that apply)

1. ☐ Anemia 11. ☐ Renal Disease

2. ☐ Cardiac Disease 12. ☐ Rh Sensitization

3. ☐ Acute/Chronic Lung Disease 13. ☐ Uterine Bleeding

4. ☐ Diabetes 14. ☐ Group B Strep

5. ☐ Genital Herpes 15. ☐ HIV/AIDS

6. ☐ Hydramnios/Oligohydramnios 16. ☐ STD

7. ☐ Hemoglobinopathies 17. ☐ Hepatitis B Positive

8. ☐ Hypertension/Preg Associated 18. ☐ Preterm Labor

9. ☐ Eclampsia 19. ☐ Placental Abnormality

10. ☐ Incompetent Cervix 20. ☐ Other:

h. Tobacco Use During Pregnancy ☐ Yes ☐ No ☐ Unknown

If Yes, Average Number of Cigarettes per Day (20 cigarettes per pack)

1. ☐ Less than pack/day 4. ☐ >2 packs/day

2. ☐ -1 pack/day 5. ☐ Unknown

3. ☐ 1-2 packs/day

i. Alcohol Use During Pregnancy ☐ Yes ☐ No ☐ Unknown

If Yes, Average Number of Drinks per Week

1. ☐ Less than 1/week 4. ☐ 7-13/week

2. ☐ 1-3/week 5. ☐ 14 or more/week

3. ☐ 4-6/week 6. ☐ Unknown

j. Drug Use During Pregnancy ☐ Yes ☐ No ☐ Unknown

If Yes, Specify Substance(s) _____

1. ☐ Less than 1/week 4. ☐ 7-13/week

2. ☐ 1-3/week 5. ☐ 14 or more/week

3. ☐ 4-6/week 6. ☐ Unknown

k. Medications Mother was Taking at Time of F/I/C Death

_____ ☐ None ☐ Unknown

l. Weight Gain During Pregnancy _____ ☐ Unknown

m. MIAMI/Home Visiting Services During Pregnancy

1. ☐ Yes 2. ☐ No 3. ☐ Unknown

n. Infant Breast Fed:

At Hospital Discharge ☐ Yes ☐ No ☐ Unknown

At Time of Death ☐ Yes ☐ No ☐ Unknown

4. FETAL/INFANT DEATHS: ADDITIONAL INFORMATION

A. MATERNAL HISTORY AT TIME OF FETAL/INFANT DEATH

1. Current or Previous History or Post Partum Depression
   ☐ Yes ☐ No ☐ Unknown
2. Total Number of Pregnancies _____
3. Total Number of Full Term Pregnancies (>=37 weeks) _____
4. Total Number of Pre Term Pregnancies _____
5. Total Number of Spontaneous or Elective Terminations _____
6. Number of Live Births _____
7. Number Now Living _____

B. PRENATAL CARE PROVIDED BY (Check all that apply)

1. ☐ Family Practice/GP, MD, DO
2. ☐ OB/GYN
3. ☐ Nurse Practitioner/PA
4. ☐ Certified Nurse Midwife
5. ☐ Lay Midwife
6. ☐ Perinatologist
7. ☐ Other: (list)

C. METHOD OF DELIVERY (Check all of the following methods of delivery that apply)

1. ☐ Vaginal
2. ☐ Vaginal Birth After Previous C-Section
3. ☐ Primary C-Section
4. ☐ Repeat C-Section
5. ☐ Forceps
6. ☐ Vacuum
7. ☐ Hysterotomy/Hysterectomy

D. COMPLICATIONS OF LABOR AND DELIVERY

(Check all that apply) ☐ Yes ☐ No ☐ Unknown

a. ☐ Febrile (>100 F. or 38 C.)
b. ☐ Meconium, Moderate/Heavy
c. ☐ Premature Rupture of Membrane >12 hrs.
d. ☐ Abruptio Placenta
e. ☐ Placenta Previa
f. ☐ Other Excessive Bleeding
g. ☐ Seizures During Labor
h. ☐ Precipitous Labor
i. ☐ Prolonged Labor (>20 hrs)
j. ☐ Dysfunctional Labor
k. ☐ Breech/Malpresentation
l. ☐ Cephalopelvic Disproportion
m. ☐ Cord Prolapse
n. ☐ Anesthetic Complications
o. ☐ Fetal Distress
p. ☐ Other: (list)

E. FETAL/INFANT BIRTH HISTORY

1. Location of Birth
   a. ☐ Hospital
   b. ☐ Outpatient Clinic
   c. ☐ Unplanned Home Delivery
   d. ☐ Out of Hospital
   e. ☐ Planned Home Delivery
2. Single or Multiple Birth (Select one)
   a. ☐ Single b. ☐ Twin c. ☐ Triplet d. ☐ Other _____

F. NEWBORN/INFANT BIRTH HISTORY

1. Apgar Score 1 minute____ 5 minutes____ ☐ Unknown
2. Abnormal Conditions of the Newborn (Check all that apply)
   a. ☐ Anemia (HCI, <39 Hgb, <13)
   b. ☐ Birth Injury
   c. ☐ Fetal Alcohol Syndrome
   d. ☐ Hyaline Membrane Disease
   e. ☐ Meconium Aspiration Syndrome
   f. ☐ Assisted Ventilation (<30 min)
   g. ☐ Assisted Ventilation (>30 min)
   h. ☐ Seizures
   i. ☐ Other: (list)
   j. ☐ None

G. CONGENITAL ANOMALIES ☐ Yes (Check all that apply) ☐ No

1. ☐ Anencephalus
2. ☐ Spina Bifida/Meningocele
3. ☐ Hydrocephalus
4. ☐ Other Central Nervous System Anomalies _____
5. ☐ Heart Malformations
6. ☐ Other Circulatory/Respiratory Anomalies _____
7. ☐ Rectal Atresia/Stenosis
8. ☐ Trachea-Esophageal Fistula/Esophageal Atresia
9. ☐ Omphalocele/Gastroschisis
10. ☐ Other Gastrointestinal Anomalies _____
11. ☐ Malformed Genitals
12. ☐ Renal Agenesis
13. ☐ Other Urogenital Anomalies _____
14. ☐ Cleft Lip/Palate
15. ☐ Polydactyl/Syndactyl/Adactylia
16. ☐ Club Foot
17. ☐ Diaphragmatic Hernia
18. ☐ Other Musculo-Skeletal Integumental Anomalies _____
19. ☐ Down Syndrome
20. ☐ Other Chromosomal Anomalies _____
21. ☐ Other:

H. WAS THE NEWBORN TRANSPORTED

☐ Yes ☐ No ☐ Unknown

If Yes, name of county or out of state facility transferred to:

I. NUMBER OF DAYS HOSPITALIZED PRIOR TO ORIGINAL DISCHARGE_____

J. INFANT CARE PROVIDERS

1. ☐ Family Practitioner
2. ☐ Pediatrician
3. ☐ General Practitioner
4. ☐ Nurse Practitioner
5. ☐ Neonatologist
6. ☐ Other _____
7. ☐ Unknown
8. ☐ None

5. SUDDEN INFANT DEATH SYNDROME (SIDS) ☐ NA

(Also complete E3)

a. Position of Infant at Discovery
1. ☐ On Stomach, Face Down
2. ☐ On Stomach, Face to Side
3. ☐ On Back
4. ☐ On Side
5. ☐ Unknown

b. Normal Sleeping Position
1. ☐ On Back
2. ☐ On Stomach
3. ☐ On Side
4. ☐ Varies
5. ☐ Unknown

c. Location of Infant When Found
1. ☐ Crib
2. ☐ Playpen
3. ☐ Other Bed _____
4. ☐ Couch
5. ☐ Floor
6. ☐ Other _____

d. Infant Sleeping Alone
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

e. Infant Healthy
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

f. Second-Hand Cigarette Exposure
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

g. Treatment for Apnea
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

h. Infant on Firm Surface
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

i. Heavy Bedding/Pillows
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

j. Overheating
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

k. Swaddled
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

l. Other Risks
1. ☐ Yes 2. ☐ No If yes, describe:

6. CHILD ABUSE AND NEGLECT ☐ NA

(Also complete section F)

a. Cause
1. ☐ Shaken Baby/Shaken Impact Syndrome
2. ☐ Beating/Battered Child
3. ☐ Inadequate Supervision...
   a. Childís Activity at the Time:

   b. Resulting Injury:

4. ☐ Medical Neglect For Religious Reasons
5. ☐ Failure to Thrive
   a. ☐ Non-Organic Failure to Thrive
   b. ☐ Malnutrition Due to Neglect
6. ☐ Munchausen Syndrome by Proxy
7. ☐ Abandonment
8. ☐ Scalding
9. ☐ Other:

b. Suspected Trigger
1. ☐ Crying
2. ☐ Disobedience
3. ☐ Feeding Difficulty
4. ☐ Toilet Training
5. ☐ Family Violence
6. ☐ Other _____
7. ☐ Unknown

c. Evidence of Prior Abuse
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

If Yes, explain:

d. Prior Record of Abuse
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

If Yes, explain:

e. Child/Family Previously Identified as High Risk for Abuse
1. ☐ Yes 2. ☐ No

If Yes, explain:

f. Prior Services/Treatment Provided
1. ☐ Yes 2. ☐ No

If Yes, specify services:

g. Was Perpetrator Identified
1. ☐ Yes 2. ☐ No

If Yes, Perpetratorís Explanation for Injuries:

7. VEHICULAR ☐ NA

a. Position of Child
1. ☐ Driver
2. ☐ Pedestrian
3. ☐ Passenger
4. ☐ Bicyclist
5. ☐ Other _____

b. Vehicle Causing Death
1. ☐ Car
2. ☐ Truck/RV
3. ☐ Motorcycle
4. ☐ Bicycle
5. ☐ SUV
6. ☐ Farm Vehicle
7. ☐ Water Craft
8. ☐ All-terrain
9. ☐ Snowmobile
10. ☐ Other _____

c. Conditions of Road (Check all that apply) ☐ NA
1. ☐ Normal
2. ☐ Ice/Snow
3. ☐ Wet
4. ☐ Loose Gravel
5. ☐ Fog
6. ☐ Unknown

d. Time of Day
☐ 6am-6pm ☐ 6pm-12 mid ☐ 12mid-6am ☐ Unknown

e. Type of Restraints Appropriate (Check all that apply)
1. ☐ Seat Belt
2. ☐ Infant Seat
3. ☐ Toddler Seat
4. ☐ Air Bag
5. ☐ Not Needed
6. ☐ Unknown

f. Restraint Used
1. ☐ Present, Not Used
2. ☐ None in Vehicle
3. ☐ Used Correctly
4. ☐ Used Incorrectly
5. ☐ Not Needed
6. ☐ Unknown

g. Helmet Use
1. ☐ Helmet Worn
2. ☐ Helmet Not Worn
3. ☐ Not Needed
4. ☐ Unknown

h. Alcohol or Other Drug Use ☐ Yes (Check all that apply) ☐ No
1. ☐ Child Impaired
2. ☐ Driver of Childís Vehicle Impaired
3. ☐ Driver of Other Vehicle Impaired
4. ☐ No Alcohol or Drugs Involved
5. ☐ Unknown

If yes, substance involved:

i. Primary Cause(s) of Incident (Check all that apply)
1. ☐ Speeding
2. ☐ Recklessness
3. ☐ Mechanical Failure
4. ☐ Poor Weather
5. ☐ Driver Error
6. ☐ Alcohol/Drugs
7. ☐ Other _____
8. ☐ Unknown

j. Age of Driver at Fault
1. ☐ <15
2. ☐ 15-16
3. ☐ 17-18
4. ☐ 19-24
5. ☐ 25-35
6. ☐ 35-59
7. ☐ >60
8. ☐ Unknown

k. Number of (Other) Teen Passengers in the Car Causing the Death
☐ None ☐ One ☐ Two ☐ Three or more

8. FIRE AND BURN ☐ NA

a. If Fire, the Source
1. ☐ Matches
2. ☐ Cigarette
3. ☐ Lighter
4. ☐ Gas Explosion
5. ☐ Explosives
6. ☐ Space Heater
7. ☐ Faulty Wiring
8. ☐ Cooking Appliance
9. ☐ Other:
10. ☐ Unknown

b. Material Ignited
1. ☐ Clothing
2. ☐ Mattress
3. ☐ Furniture
4. ☐ Other:

c. Smoke Alarm Present
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

d. Smoke Alarm with Good Battery
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

e. Smoke Alarm Functioning Properly
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

f. Fire Started By
1. ☐ Victim 2. ☐ Other 3. ☐ No One 4. ☐ Unknown

g. Activity of the Person Starting the Fire
1. ☐ Playing
2. ☐ Smoking
3. ☐ Cooking
4. ☐ Suspected Arson
5. ☐ Other:
6. ☐ Unknown

h. Construction of Fire Site
1. ☐ Wood Frame Home
2. ☐ Brick Frame Home
3. ☐ Trailer
4. ☐ Other:
5. ☐ Unknown

i. For Building Fire, Where Was Child Found
1. ☐ Hiding
2. ☐ In Bed
3. ☐ Stairway
4. ☐ Close to Exit
5. ☐ Other:
6. ☐ Unknown

j. If Burn, the Source
1. ☐ Hot water
2. ☐ Appliance
3. ☐ Cigarettes
4. ☐ Heater
5. ☐ Chemicals
6. ☐ Other:
7. ☐ Unknown

k. If Water Burn, Was the Child Intentionally Immersed?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

9. DROWNING AND SUBMERSION ☐ NA

a. Place of Drowning
1. ☐ Lake, River, Pond
2. ☐ Bathtub
3. ☐ In-Ground Swimming Pool
4. ☐ Above-Ground Swimming Pool
5. ☐ Well or Cistern
6. ☐ Bucket
7. ☐ Drainage Ditch
8. ☐ Other:

b. Activity at Time of Drowning
1. ☐ Boating
2. ☐ Playing at Waterís Edge
3. ☐ Swimming
4. ☐ Playing
6. ☐ Bathing
7. ☐ Other:
8. ☐ Unknown

c. Was Child Wearing a Flotation Device?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

d. Did Child Enter a Gate Unattended?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

e. If Yes Was Gate Locked?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

f. If Swimming, Could Child Swim?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

g. Were Alcohol or Other Drugs a Factor?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

h. If Pool, Was It Completely Fenced?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

10. FALLS ☐ NA

a. Child Fell From
1. ☐ Open window
2. ☐ Furniture
3. ☐ Natural Elevation
4. ☐ Crib
5. ☐ Stairs/Steps
6. ☐ Bridge
7. ☐ Other: (list)

b. Was Child in a Baby Walker?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

c. Was Child Thrown or Pushed Down?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

11. POISONING ☐ NA

a. Type of Poisoning
1. ☐ Alcohol (Estimated Amount) _____
2. ☐ Prescription Medicine (name) _____
3. ☐ Over-the-Counter Medicine (name) _____
4. ☐ Chemical (name) _____
5. ☐ Carbon Monoxide or Other Gas Inhalation
6. ☐ Foodstuff
7. ☐ Other:

b. Safety Cap on Bottle?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

c. Location of Poison
1. ☐ In Cabinet with Locks or Safety Latch
2. ☐ In Cabinet without Locks or Safety Latch
3. ☐ On Counter, Table or Floor
4. ☐ Outside or in Garage
5. ☐ Unknown

12. ELECTROCUTION ☐ NA

a. Source of Electricity
1. ☐ Water Contact
2. ☐ Electric Wiring
3. ☐ Electrical Outlet
4. ☐ Appliance
5. ☐ Tool
6. ☐ Lighting
7. ☐ Other: (list)

b. Was Source Defective?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

13. FIREARMS AND WEAPONS ☐ NA

a. Person Handling the Weapon
1. ☐ Child
2. ☐ Family Member
3. ☐ Acquaintance
4. ☐ Friend
5. ☐ Stranger
6. ☐ Unknown

b. Age of Person Handling Weapon_____years.

c. Type of Weapon
1. ☐ Handgun
2. ☐ Rifle
3. ☐ Shotgun
4. ☐ Knife
5. ☐ Unknown
6. ☐ Other:

d. If Handgun, Was it Registered?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

e. Use of Weapon at Time
1. ☐ Intending to Harm
2. ☐ Cleaning
3. ☐ Hunting
4. ☐ Loading
5. ☐ Demonstrating
6. ☐ Playing
7. ☐ Other
8. ☐ Unknown

f. Did Person Handling Firearm attend Safety Classes?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

g. Was Firearm in Locked Cabinet?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

h. Did Firearm Have a Trigger Lock?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

14. SUFFOCATION AND STRANGULATION ☐ NA

a. Circumstances of Event
1. ☐ Other Person Lying On or Rolling On Child
2. ☐ Child On or Covered by Object
3. ☐ Other Person Using Hands or Object to Suffocate/Strangle
4. ☐ Child Choking on Object
5. ☐ Child Strangled by Object

b. Object Causing Suffocation or Strangulation
1. ☐ Food (specify) _____
2. ☐ Plastic Bag
3. ☐ Rope/String
4. ☐ Bedding Type _____
5. ☐ Toy
6. ☐ Small Object
7. ☐ Balloon
8. ☐ Person
9. ☐ Other:
10. ☐ Unknown

c. Location of Child at the Time of Incident
1. ☐ Crib
2. ☐ In Bed Alone
3. ☐ In Bed With Others
4. ☐ Held in Arms
5. ☐ Playing
6. ☐ Other: (list)

d. Was Child Sleeping? ☐ NA
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

If Yes...
1. Was the Design of Bed Hazardous ☐ Yes ☐ No
2. Was the Child on Soft Surface ☐ Yes ☐ No
3. Was Child in Heavy Bedding ☐ Yes ☐ No
4. Was the Child Sleeping with Others ☐ Yes ☐ No
   a. If Yes, was Obesity a Factor ☐ Yes ☐ No
   b. If Yes, Number and Ages of Persons:

15. ANY OTHER CAUSE: Describe the Circumstances

F. INFLICTED INJURIES ☐ NA

a. Was the Injury Intentional?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

b. If Intentional, Was the Infant/Child
1. ☐ Intended victim 2. ☐ Random victim (e.g.: in the line of fire)

c. Was the Injury Drug Related?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

d. Was the Injury Gang Related?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

e. Person(s) Inflicting Injury (Check all that apply)
1. ☐ Self
2. ☐ Mother
3. ☐ Father
4. ☐ Stepmother
5. ☐ Stepfather
6. ☐ Motherís Boyfriend
7. ☐ Fatherís Girlfriend
8. ☐ Foster Parent
5. ☐ Acquaintance
6. ☐ Friend
7. ☐ Child Care Worker
12. ☐ Sibling
13. ☐ Other Child
14. ☐ Stranger
15. ☐ Other:
16. ☐ Unknown

f. If Intentional, Status of Perpetrator (Check as many as apply)
1. ☐ Arrested
2. ☐ Charges Filed
3. ☐ Has Record for Similar Offense
4. ☐ Under the Influence of Alcohol/Drugs
5. ☐ Was Receiving Preventative Services
6. ☐ Fled Jurisdiction
7. ☐ Deceased

g. If Suicide (Check all that apply)
1. ☐ Prior Attempts
2. ☐ Prior Mental Health Problems
3. ☐ Previous Mental Health Services
4. ☐ Possible Cluster Suicide
5. ☐ Suicide Completely Unexpected
6. ☐ Precipitating Event(s), Describe:

G. PREVENTION & TEAM FINDINGS

Must complete every question.
A preventable death is one in which, WITH RETROSPECTIVE ANALYSIS, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available.

1. WAS THERE ENOUGH INFORMATION ABOUT THIS DEATH TO DETERMINE PREVENTABILITY? ☐ Yes ☐ No

2. TO WHAT DEGREE WAS THIS DEATH BELIEVED TO BE PREVENTABLE?

a. ☐ **NOT AT ALL**

Why was this death not preventable?

b. ☐ **DEFINITELY**

If definitely, explain:

c. ☐ **CANNOT BE DETERMINED**

If undetermined, explain:

3. PRIMARY RISK FACTORS INVOLVED IN DEATH
(Check as many as apply)

1. ☐ Medical
2. ☐ Social
3. ☐ Behavioral
4. ☐ Economic
5. ☐ Environmental
6. ☐ Product Safety

List examples below and match to risk factors identified (i.e., Behavioral-Smoking):

4. WHAT PREVENTION ACTIVITIES HAVE BEEN PROMPTED BY THE REVIEW SINCE THE DEATH (Check all that apply)

	1. Proposed	2. Initiated
a. Advocacy	☐	☐
Describe:		
b. Legislation, Law or Ordinance	☐	☐
c. Community Safety Project	☐	☐
d. Product Safety Action	☐	☐
e. Educational Activities in Schools	☐	☐
f. Educational Activities in Media	☐	☐
g. Public Forums	☐	☐
h. New Services	☐	☐
i. Changes in Agency Practice	☐	☐
j. Other Programs or Activities	☐	☐
k. None	☐	☐
l. Other:		

5. TARGET POPULATIONS FOR PREVENTION ACTIVITIES
(Check all that apply)

a. ☐ Children
b. ☐ General Population
c. ☐ Parents and Other Caregivers
d. ☐ Professionals
e. ☐ Others _____
f. ☐ Does Not Apply

H. REVIEW TEAM PROCESS

1. DID PANEL MEMBERS CONCUR ON THE CAUSE AND MANNER OF DEATH AS LISTED ON DEATH CERTIFICATE?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

2. WAS THE DESIGNATION OF CAUSE AND MANNER OF DEATH CHANGED AFTER THE REVIEW?
1. ☐ Yes 2. ☐ No
If Yes, Specify:

3. DID THE REVIEW LEAD TO ADDITIONAL INVESTIGATION?
1. ☐ Yes 2. ☐ No
If Yes, Specify By Whom:

4. WERE ADDITIONAL SERVICES PROVIDED AS A RESULT OF THE REVIEW?
1. ☐ Yes 2. ☐ No
If Yes, Specify:

5. WERE CHANGES TO LOCAL POLICIES OR PRACTICES RECOMMENDED AS A RESULT OF THIS REVIEW?
(check all that apply)

1. ☐ Yes 2. ☐ No 3. ☐ Unknown

If Yes:

a. ☐ Public Health
b. ☐ Child and Family Services
c. ☐ Other Social Services
d. ☐ Medical Examiner
e. ☐ Law Enforcement
f. ☐ Local Government
g. ☐ State Government
h. ☐ Fire
i. ☐ Education
j. ☐ EMS
k. ☐ Court/Prosecutor
l. ☐ Hospital
m. ☐ Other: (describe)

6. WHICH RECORD(S) WAS THE TEAM UNABLE TO ACCESS

☐ None

a. ☐ Hospital
b. ☐ Other Medical
c. ☐ EMS
d. ☐ Coroner
e. ☐ Birth Record
f. ☐ CFS
g. ☐ Law Enforcement
h. ☐ Court
i. ☐ School
j. ☐ Mental Health
k. ☐ Health Department
l. ☐ Autopsy
m. ☐ Other _____

7. SHOULD THIS CASE BE REFERRED TO THE STATE TEAM FOR A SECOND REVIEW?

a. ☐ Yes b. ☐ No

I. NARRATIVE

Provide any additional information that you feel may help to more completely understand issues related to the circumstances of this death, the delivery of services, prevention, or the review process.

J. TEAM PARTICIPATION

Must complete

CHECK ALL WHO WERE PRESENT FOR THE REVIEW

☐ County Attorney or Designee
☐ Law Enforcement
☐ Medical Examiner
☐ Coroner
☐ School District
☐ Pediatrician
☐ Family Practice Physician
☐ Obstetrician/CNM
☐ Nurse Practitioner
☐ Public Health Nurse
☐ Child and Family Services
☐ Social Worker
☐ Mental Health
☐ Local Trauma Coordinator
☐ Tribal Health Representative
☐ Bureau of Indian Affairs/ Indian Health Service
☐ Emergency Medical Services (EMS)
☐ Hospital Representative
☐ Hospital Medical Records
☐ Fire Department
☐ Local Registrar
☐ Neonatologist
☐ Perinatologist
☐ Other: (list)

NAME OF PERSON COMPLETING THE FORM:	DATE REVIEW COMPLETED: (mm/dd/yyyy)	TELEPHONE NUMBER: